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IN THE
Supreme Court of the United States

OCTOBER TERM, 1989

FMC CORPORATION,
Petitioner,
v.

CYNTHIA ANN HOLLIDAY,
Respondent.

On Writ of Certiorari to the United States
Court of Appeals for the Third Circuit

BRIEF OF THE NATIONAL COORDINATING
COMMITTEE FOR MULTIEMPLOYER PLANS AS
AMICUS CURIAE IN SUPPORT OF PETITIONER

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
PRELIMINARY STATEMENT	1
INTEREST OF THE NCCMP	2
SUMMARY OF ARGUMENTS	8
ARGUMENTS	10
I. THE THIRD CIRCUIT'S DECISION WILL SUBSTANTIALLY LIMIT THE ABILITY OF MULTIEMPLOYER PLAN TRUSTEES TO DESIGN AND IMPLEMENT COST-CONTAINMENT STRATEGIES IN RESPONSE TO ESCALATING HEALTH CARE COSTS, THEREBY UNDERMINING THE ABILITY OF MULTIEMPLOYER PLANS TO PAY THE BENEFITS PROMISED IN THE PLAN	10
A. The Third Circuit's ruling will interfere with the efficient administration of multi-employer welfare plans because of the nature of such plans and the duties of their trustees	10
B. State law should not be permitted to interfere with core ERISA concerns by preventing plan sponsors from designing and implementing uniform cost-containment strategies in response to escalating health care costs....	14
II. SECTION 514(b)(2)(B) OF ERISA WAS INTENDED TO PREEMPT ALL STATE INSURANCE REGULATION AFFECTING SELF-FUNDED EMPLOYEE BENEFIT PLANS AND THE THIRD CIRCUIT'S RULING IS INCONSISTENT WITH DECISIONS OF THIS COURT AND THE WEIGHT OF APPELLATE AUTHORITY	22

TABLE OF CONTENTS—Continued

	Page
A. The Third Circuit's ruling abandons the bright-line test for preemption that is necessary for the uniform administration of multiemployer plans	22
B. This Court's distinction between insured and self-funded plans is consistent with the text and legislative history of ERISA and should be reaffirmed in the case at bar	27
CONCLUSION	30

TABLE OF AUTHORITIES

CASES:	Page
<i>Baxter v. Lynn</i> , 886 F.2d 182, <i>reh'g denied</i> , — F.2d — (8th Cir. 1989)	22
<i>Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.</i> , 472 U.S. 559 (1985)	3
<i>Children's Hosp. v. Whitcomb</i> , 778 F.2d 239 (5th Cir. 1985)	22
<i>Connolly v. Pension Benefit Guaranty Corp.</i> , 475 U.S. 211 (1986)	3
<i>FMC Corporation v. Holliday</i> , 885 F.2d 79 (3d Cir. 1989)	23, 25
<i>Fort Halifax Packing Co. v. Coyne</i> , 482 U.S. 1 (1989)	28, 29
<i>Howard v. Alfrey</i> , 697 F.2d 1006 (11th Cir. 1983)	21
<i>Jim McNeff, Inc. v. Todd</i> , 461 U.S. 260 (1983)	3
<i>Liberty Mutual Ins. Group v. Iron Workers Health Fund of Eastern Michigan</i> , 879 F.2d 1384 (6th Cir. 1989)	13, 26
<i>Metropolitan Life Ins. Co. v. Massachusetts</i> , 471 U.S. 724 (1985)	4, 9, 13, 21, 22, 23, 25, 27, 28, 30
<i>Nachman v. Pension Benefit Guaranty Corp.</i> , 446 U.S. 359 (1980)	14
<i>Northern Group Services, Inc. v. Auto Owners Ins. Co.</i> , 833 F.2d 85 (6th Cir. 1987), <i>cert. denied</i> , 486 U.S. 1017 (1988)	18, 19, 23, 25, 26
<i>Pension Benefit Guaranty Corp. v. R.A. Gray Co.</i> , 467 U.S. 717 (1984)	3
<i>Powell v. Chesapeake & Potomac Tel. Co.</i> , 780 F.2d 419 (4th Cir. 1985), <i>cert. denied</i> , 476 U.S. 1170 (1986)	22
<i>Reilly v. Blue Cross & Blue Shield United of Wisconsin</i> , 846 F.2d 416 (7th Cir. 1988), <i>cert. denied</i> , 109 S. Ct. 145 (1988)	22
<i>United Food & Commercial Workers v. Pacyga</i> , 801 F.2d 1157 (9th Cir. 1986)	22, 23
<i>Union Labor Life Ins. Co. v. Pireno</i> , 458 U.S. 119 (1982)	25

TABLE OF AUTHORITIES—Continued

STATUTES:	Page
Employee Retirement Income Security Act of 1974 (ERISA)	2
29 U.S.C. 1001	2
29 U.S.C. § 1001 <i>et seq.</i>	2
29 U.S.C. § 1002 (1)	27
29 U.S.C. § 1003 (a)	28
29 U.S.C. § 1022	6, 13
29 U.S.C. § 1024 (b)	6, 13
29 U.S.C. § 1102	27
29 U.S.C. § 1103	6, 27
29 U.S.C. § 1104 (a) (1) (B)	17
29 U.S.C. § 1104 (a) (1) (D)	7, 14
29 U.S.C. § 1144	3, 28
29 U.S.C. § 1144 (b) (2) (A)	28
29 U.S.C. § 1144 (b) (2) (B)	22, 28
Multiemployer Pension Plan Amendments Act of 1980, Pub. L. 96-364, 94 Stat. 1208 (1980)	2
Labor-Management Relations Act of 1947	27
29 U.S.C. § 186 (1) (5)	27
Pennsylvania Motor Vehicle Financial Responsibility Law of 1984, 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984)	3
LEGISLATIVE MATERIALS:	
120 Cong. Rec. 29197 (1974)	29
120 Cong. Rec. 29933 (1974)	29
126 Cong. Rec. S9835 (daily ed. July 24, 1980)	2
126 Cong. Rec. S10100 (daily ed. July 29, 1980)	2
OTHER AUTHORITIES:	
Burroughs & Zurawell, <i>Health, Welfare Funds Suffer Sharply from Higher Health Costs</i> , 25 Pens. World No. 11 at 24 (Nov. 1989)	16
<i>Consumer Spending Increased Most for Health Care, Transportation in 1988</i> , Daily Lab. Rep. (BNA) No. 39 at B-1 (Feb. 27, 1990)	16
<i>Data Watch: What's Driving Health Care Costs?</i> , 7 Business and Health No. 1 at 6 (Jan. 1989)	15

TABLE OF AUTHORITIES—Continued

	Page
<i>Disputes Over Health Care Costs Root of Many Strikes, Report Finds</i> , 17 Pens. Rep. (BNA) 375 (Feb. 26, 1990)	18
<i>Employee Benefits in Medium and Large Firms, 1988</i> , DOL Bur. of Lab. Stat. Bull. No. 2336 at 36 (Aug. 1989)	16
<i>Health Benefit Costs Up Sharply in 1988, Chamber of Commerce Finds</i> , 7 Benefits Today (BNA) No. 1 at 16 (Jan. 12, 1990)	16
<i>Health Care Costs</i> , 23 Bus. Ins. No. 40 at 6 (Oct. 2, 1989)	15
<i>Health Care Costs Continue to Climb</i> , 23 Bus. Ins. No. 52 at 18 (Dec. 25, 1989)	16
<i>Health Costs Play Major Role in Bargaining</i> , 16 Pens. Rep. (BNA) 2025 (Nov. 27, 1989)	18
<i>Health Expenditures Surpass 11 Percent of GNP, 10 Employee Benefit Notes</i> No. 2 at 3 (Feb. 1989)	15
<i>NCCMP Chairman Georgine Urges Uniform National Health Care Policy</i> , NCCMP Update (Winter 1989-1990)	11
<i>NYNEX Workers Ratify Three-Year Contract by 85 Percent Margin to End 17-Week Strike</i> , 16 Pens. Rep. (BNA) 2094 (Dec. 11, 1989)	18
<i>Survey Finds 20.4 Percent Increase in Employer Medical Plan Costs in 1989</i> , 17 Pens. Rep. (BNA) 260 (Feb. 5, 1990)	15
<i>Tokarski, Healthcare Spending Expected to Rise 10%</i> , 20 Modern Healthcare No. 1 at 34 (Jan. 8, 1990)	16
<i>Vincenzino, Trends in Medical Care Costs: A Look at the 1990s</i> , 71 Statistical Bull. No. 1 at 28 (Jan.-Mar. 1990)	15
<i>Wille, Subrogation/Third-Party Reimbursement: An Overlooked Way to Reduce Health Benefit Costs</i> , 1 Health Cost Management No. 9 at 3 (June 1984)	20

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PRELIMINARY STATEMENT

The National Coordinating Committee for Multiemployer Plans ("NCCMP") submits this brief *amicus curiae*¹ to urge the Court to reverse the holding below.

Contrary to an express mandate of Congress and previous rulings of this Court, the ruling of the Third Circuit, if not reversed, will give a preemptive effect to state automobile insurance statutes and presumably to other state insurance laws as well. The ruling will therefore inhibit the trustees of multiemployer employee benefit plans from designing cost-containment strategies to protect and improve the financial soundness of the

¹ Letters manifesting the consent of Petitioner and Respondent have been filed with the Clerk of the Court.

plans (such as subrogation and coordination of benefits) and bar them from implementing such strategies through enforcement of their plan documents in any state in which the plan provisions, though consistent with ERISA and with federal employee benefits policy, are found to be inconsistent with local insurance law.

By enacting ERISA, Congress sought to enhance the financial stability of multiemployer plans and to foster the growth and maintenance of such plans. 29 U.S.C. § 1001. The NCCMP files this brief because the decision below is contrary to those goals.

INTEREST OF THE NCCMP

The NCCMP is a nonprofit, tax-exempt organization that was formed after enactment of the Employee Retirement Income Security Act of 1974,² 29 U.S.C. § 1001 *et seq.* ("ERISA"), to participate in the development of employee benefits legislation, government regulations promulgated to implement ERISA, and other laws affecting multiemployer plans. Currently, more than 190 multiemployer plans and related international unions, located in at least 37 states, are affiliated with the NCCMP. These plans are representative of all of the nation's multiemployer plans which cover more than nine million workers. The decision below has far-reaching adverse consequences for all multiemployer plans and, therefore, is particularly adverse to the interests of NCCMP affiliates which represent the majority of participants in such plans.

Because of the broad range of experience of the NCCMP's constituent organizations and its close ongoing

² ERISA was amended in 1980 by the Multiemployer Pension Plan Amendments Act of 1980, Pub. L. 96-364, 94 Stat. 1208 (1980). The NCCMP has been recognized as having had a "significant impact" on this statute by the Senate cosponsors of that legislation. See 126 Cong. Rec. S9835 (daily ed., July 24, 1980) and S10100 (daily ed., July 29, 1980).

contacts with hundreds of trustees charged with the administration of multiemployer plans in accordance with ERISA's fiduciary duty rules and principles, the NCCMP believes that it is qualified to provide the Court with insight into the practical implications of the decision below for multiemployer plans and to state the position of the trustees, participants, and beneficiaries of such plans. In fact, the NCCMP has recently participated as an *amicus curiae* in *Connolly v. PBGC*, 475 U.S. 211 (1986); *Central States, Southeast and Southwest Areas Pension Fund v. Central Transport, Inc.*, 472 U.S. 559 (1985); *PBGC v. R.A. Gray & Co.*, 467 U.S. 717 (1984); and *Jim McNeff, Inc. v. Todd*, 461 U.S. 260 (1983).

In the decision below, the Court of Appeals for the Third Circuit, departing from the text of ERISA's preemption provision, 29 U.S.C. § 1144, as well as its construction by this Court, courts of appeals of the majority of other circuits, and numerous district courts, ruled that Petitioner FMC Corporation, a self-funded single-employer health benefit plan subject to ERISA, could not enforce the plan's subrogation provision because a Pennsylvania automobile insurance statute contains a general provision barring subrogation.³ Thus, FMC was held barred from seeking any reimbursement of medical expenses which the plan paid pursuant to a participant's claim for benefits in connection with an injury resulting from an automobile accident,⁴ although the claimant expressly agreed, as a condition for receiving the benefits, that he would reimburse the plan if he effected a recovery from any third party and did, in fact, recover.

³ The Pennsylvania Motor Vehicle Financial Responsibility Law of 1984, 75 Pa. Cons. Stat. Ann. § 1720 (Purdon 1984).

⁴ The claim was made by respondent's father, an employee of FMC Corporation, on behalf of his minor daughter, a covered dependent, who was injured while a passenger in the affected car. (The facts are set forth in Petitioner's Brief.)

While acknowledging that the Pennsylvania statute "related to" an employee benefit plan, the Third Circuit ruled that it was "saved" from ERISA preemption as a state law regulating insurance. Although the FMC Plan was admittedly a self-funded plan rather than one providing benefits through the purchase of insurance, the court of appeals rejected the bright-line distinction between insured and self-funded plans set forth by this Court in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), and ruled that the "deemer" clause was inapplicable to the FMC plan because the Pennsylvania law did not conflict with a "core" ERISA concern.

The NCCMP submits that the decision below will have a significant adverse impact not only upon self-funded single-employer plans but upon its own affiliated plans as well as all of the nation's self-funded multiemployer plans, thereby undermining federal employee benefits law and policy as established and envisioned by Congress.

Multiemployer plans are created pursuant to collective bargaining agreements and are funded by contributions made by more than one employer, which are pooled for investment to pay benefits to all of the fund's participants and beneficiaries. Typically, even small multiemployer plans provide benefits to participants working or residing in more than one state; large national plans may have participants and beneficiaries in all 50 states.⁵ These states all have automobile insurance laws of varying kinds whose provisions may, in many cases, differ

⁵ By way of example, one of the relatively small welfare plans affiliated with NCCMP, the Southern Electrical Health Fund, although administered in Goodlettsville, Tennessee has processed benefit claims as well as subrogation claims on behalf of participants working or residing in at least five other states: Georgia, Alabama, South Carolina, Tennessee and New Jersey. A large affiliate, such as the nationwide Hotel Employees and Restaurant Employees Welfare Fund, which is centrally administered in Naperville, Illinois, has participants throughout the United States.

from the subrogation and coordination of benefits provisions of individual plans.

The NCCMP is concerned, first, that unless the Third Circuit's ruling is reversed, the trustees and administrators of multiemployer plans will be unable to establish and implement uniform administrative guidelines for the processing of claims and disbursement of benefits because plans having participants in different states—even if self-funded—will be subject to different regulatory requirements.

Second, it is well known that the cost of providing medical benefits has soared in recent years and shows no sign of abatement. At the same time, bargaining over health benefits has become a central issue in negotiating collective bargaining agreements and has been a major cause of strikes and other work stoppages throughout the country. As a result of economic pressures, self-funded multiemployer plans have been required to adopt a variety of cost-containment strategies while at the same time striving to maintain, to the extent possible, the benefits previously available to the plan's participants and beneficiaries and even to improve those benefits without imposing additional financial burdens.

Subrogation and coordination of benefits prevent plan participants from recovering double payments for the same illness or injury. As cost-containment strategies, they are particularly favored by multiemployer plans because they help conserve plan assets without restricting the benefits previously available and without imposing additional costs either on employers (through increased contribution rates) or on participants and beneficiaries (through increased deductibles and co-payment requirements).

The NCCMP is concerned that the Third Circuit's ruling, if not reversed, will make it impossible for multiemployer plans having participants in certain states to

utilize or to utilize fully subrogation and coordination of benefits as cost-containment strategies, thereby reducing the plan's ability to provide the desired health benefits at a cost contributing employers as well as plan participants and beneficiaries can reasonably afford, a result which may well have a substantial adverse impact on collective bargaining and could lead to a loss of participants (and contributions) not only for multiemployer welfare plans but for sister pension plans in affected industries as well.⁶

Third, ERISA gives trustees "exclusive authority and discretion to manage and control the assets of the plan." 29 U.S.C. § 1103. The statute, which has its roots in trust law, does not particularize the steps trustees must take to preserve, collect, increase, or disburse (in the form of benefits) the trust assets they control except to impose upon them certain fiduciary obligations. Hence, the details of trust administration must be set forth in a written trust agreement as well as in a written benefit plan which, together with the rules and regulations promulgated by the trustees to implement these plan documents, have critical importance in ERISA's administrative scheme. Typically, subrogation and coordination of benefits provisions are to be found in the benefit plan itself which, in turn, is explained to participants and beneficiaries in the "summary plan description" required by law. 29 U.S.C. §§ 1022, 1024(b).

Although ERISA imposes upon trustees a fiduciary duty to act in accordance with the plan's documents, so long as these documents are consistent with the objectives

⁶ Typically, employers who contribute to multiemployer welfare plans pursuant to collective bargaining agreements also contribute to multiemployer pension plans. Higher contribution rates mean that a greater percent of the total wage package will be devoted to employee benefits or that the total cost of labor will increase. Either result increases the risk that employers will bargain out of multiemployer plans, thereby depleting the contribution pool necessary to pay benefits.

of the statute, 29 U.S.C. § 1104(a)(1)(D), the Third Circuit's ruling would bar trustees from uniformly enforcing a plan's subrogation and coordination of benefits provisions, even though such provisions are consistent with ERISA, in the event such provisions are found to be inconsistent with state law.

In its opinion, the Third Circuit enunciated a new and confusing test to determine whether a state insurance law should survive ERISA preemption. Under the new test, state law would be "saved" from preemption *unless* it conflicts with a "core" ERISA concern. In upholding the Pennsylvania insurance law in question, the court of appeals failed to appreciate that application of this state statute would undermine *core* ERISA concerns in *two* respects directly related to ERISA's fiduciary duty provision; the state law should therefore have been held preempted even under the court's own test. First, since the state statute would permit only selective enforcement of the FMC benefit plan, its application undermines a paramount federal interest in the uniform enforcement of plan documents except those that are inconsistent with *ERISA*; second, since the state statute would prevent enforcement, specifically, of the plan's subrogation provision, its application undermines the plan sponsor's cost-containment program which was designed to conserve and maximize plan assets so that the plan could continue to pay scheduled benefits in spite of escalating health care costs.

The NCCMP fears that the Third Circuit's new test will erode the "deemer" clause and "save" a whole variety of state statutes and common law rules regulating insurance, banking and securities, since courts are likely to differ on what they perceive as "core" ERISA concerns. The NCCMP is therefore concerned that the ruling, unless reversed, will not only increase the probability of litigation but will ultimately undermine the integrity and enforceability of plan documents generally.

Such a result will therefore undermine the ability of multiemployer plan trustees to recover monies owed to the trusts not only pursuant to such cost-containment programs as subrogation but in other areas of trust administration as well. Contrary to ERISA's goals, this result will ultimately undermine the ability of welfare and pension plans to maintain and pay the benefits promised to and relied upon by the plan's participants and beneficiaries.

The NCCMP's brief focuses on issues which it believes may not be adequately presented elsewhere, including:

(a) The particularly adverse impact that the holding below will have on the multitude of multiemployer plans represented by the NCCMP as well as upon national employee benefits policy; and

(b) The fundamental conflict between decisions of this Court, as well as those of other federal circuits, and the decision of the Court below.

SUMMARY OF ARGUMENTS

ERISA does not regulate the substantive details of trust administration or the substantive content of self-funded multiemployer welfare plans. However, the statute does impose certain fiduciary duties on the trustees of such plans: to act with prudence and reasonableness in the circumstances, to conserve plan assets, to pay benefits to participants and beneficiaries, and to comply with governing plan documents. By permitting a state insurance law to preclude enforcement of a plan provision that is consistent with ERISA, the Third Circuit's ruling has undermined the ability of multiemployer plan trustees, generally, to rely on the plan's governing documents to implement a uniform administrative system for the collection, disbursement, and conservation of trust assets.

By permitting a state insurance law to preclude enforcement of a plan's subrogation provision, the Third

Circuit's ruling has undermined the ability of multiemployer plan trustees to respond effectively to escalating health care costs, specifically, by designing and implementing uniform cost-containment strategies that are least burdensome to all of the plan's participants and beneficiaries as well as to employers funding the plan through collectively-bargained contributions. The trustees are therefore hampered in taking prudent, reasonable action that is likely to be least disruptive of labor peace and least likely to result in employers bargaining out of the plan, thereby reducing the contribution pool needed to pay scheduled benefits.

There can be no state interest in permitting plan participants to reap a double recovery for medical expenses paid while health care costs are threatening to destroy the private welfare system. However, by giving preference to a state's insurance scheme, the Third Circuit has undermined "core" ERISA concerns without even recognizing or correctly identifying their existence. The NCCMP therefore urges this Court to reaffirm the bright-line interpretation of the "deemer" clause set forth in *Metropolitan Life*, which has been followed by a majority of appellate courts, and thereby protect multiemployer benefit plans and their participants and beneficiaries from a patchwork of state insurance regulations, as Congress intended.

ARGUMENTS

I. THE THIRD CIRCUIT'S DECISION WILL SUBSTANTIALLY LIMIT THE ABILITY OF MULTI-EMPLOYER PLAN TRUSTEES TO DESIGN AND IMPLEMENT COST-CONTAINMENT STRATEGIES IN RESPONSE TO ESCALATING HEALTH CARE COSTS, THEREBY UNDERMINING THE ABILITY OF MULTIEMPLOYER PLANS TO PAY THE BENEFITS PROMISED IN THE PLAN.

A. The Third Circuit's ruling will interfere with the efficient administration of multiemployer welfare plans because of the nature of such plans and the duties of their trustees.

The Third Circuit's ruling places substantial restrictions on the ability of plan sponsors of all self-funded welfare plans to respond flexibly, as Congress intended, to the escalating costs of health care by designing and implementing cost-containment programs to conserve fund assets while continuing to pay the scheduled benefits promised in the plan. To help the Court evaluate the particularly adverse effect that the ruling is likely to have on the administration and financial soundness of multiemployer plans, the NCCMP presents a brief review of the nature of these plans, the duties of their trustees, and the centrality of plan documents to ERISA's administrative scheme.

Multiemployer employee welfare benefit plans are plans created by the parties to collective bargaining agreements for the purpose of providing health and welfare benefits to workers and their families.⁷ These plans are self-funded primarily through the ongoing contributions of several, hundreds or even thousand of employers

⁷ Many multiemployer plans also provide some type of coverage to retirees and their families. The cost of providing coverage to retirees places a particular burden on multiemployer plans, although such coverage is sorely needed.

in one or more industries involving participants working or living in several or many states.⁸ The contributions are pooled for investment to provide benefits to all participants and beneficiaries of the plan.⁹ Moreover,

⁸ Employers contributing to plans affiliated with the NCCMP are primarily in the building and construction trades. However, a substantial number of employers are also in the food, hotel and restaurant, garment, and shipping industries. Representative plans cover asbestos workers, bakery, confectionery and tobacco workers, boilermakers, bricklayers, carpenters, cement masons, electrical workers, commercial and retail food workers, garment workers, glassworkers, glaziers, ironworkers, hotel and restaurant employees, laborers, millwrights, operating engineers, painters, plumbers and pipefitters, roofers, seafarers and other maritime employees, and textile workers. These plans have administrative headquarters in at least 37 states and cover participants and beneficiaries throughout the country. Large and small employers contribute to the plans pursuant to master labor agreements and individual collective bargaining agreements.

In October 1989, Robert A. Georgine, NCCMP Chairman, testified before the House Subcommittee on Labor Management Relations on the need for federal preemption of state laws as part of a national health policy. Mr. Georgine summarized the nature of multiemployer plans and their corresponding funding problem as follows:

To fully appreciate the Coordinating Committee's position, one must understand the nature of multiemployer plans. The primary source of multiemployer plan financing is current employer contributions. Since those contributions are based typically on work performed by covered workers (e.g., dollars-per-hour-worked), the plan's income fluctuates according to increases and decreases in covered work. Contribution rates are set normally for the term of an employer's collective bargaining agreement (often three to five years). Accordingly, multiemployer plans cannot increase their income quickly or easily. Unlike single employer plans, they do not have access to a corporate treasury.

The plan's board of trustees must balance the plan's benefit structure with expected income. This is often an exercise in allocating a "fixed economic pie" among the needs and wants of the workers and families covered by the plan.

NCCMP Update at 5 (Winter 1989-1990).

a key feature of multiemployer plans is that participants can move from one contributing employer to another within the plan without losing their benefit rights, making such plans a model for portability.

While the parties to collective bargaining agreements negotiate the rate of contributions the employer will agree to pay during the life of the contract as well as the job classifications of employees to be covered by the agreement, the trustees of multiemployer plans generally have sole authority and exclusive power to determine the type and range of benefits the plan can and will provide and to establish eligibility requirements, given the plan's financial resources and such actuarial considerations as the number and age of participants and previous claims experience. Typically, the trust agreement governing the plan will establish the trustees' authority in this area,¹⁰ and will empower them to establish benefit schedules and eligibility requirements, to establish a uniform scheme for processing and reviewing benefit claims, to construe the plan, to make binding resolutions of benefit disputes, and to amend the trust agreement and/or plan in response to perceived needs.

The plan of benefits itself, as distinct from the trust agreement, normally enumerates the plan's eligibility

¹⁰ For example, Article Five, Section Six of the Trust Agreement governing the Hotel Employees and Restaurant Employees Welfare Fund empowers the Trustees "to adopt rules and regulations for the administration of the Welfare Fund and Welfare Plan and to promulgate the amount and nature of benefits payable to employees and dependents, the eligibility requirements for receiving benefits with respect to participation, length of service, and other conditions for obtaining welfare benefits, which the Trustees, in their sole discretion, may deem necessary and proper to effectuate the purposes of this Trust, and from time to time to alter, amend or change eligibility requirements as may be justifiable, to provide for portability of service for the payment of benefits, and to enter into reciprocity agreements with other welfare funds or plans; provided, however, that the exercise of such authority shall be on an actuarially sound basis."

requirements, the specific benefits provided, the specific benefits excluded, restrictions and limitations on benefits provided (including life-time ceilings and coordination of benefits), the participants' obligations (including deductibles, co-payment requirements, and subrogation), as well as information concerning the submission of claims and the right to appeal. In turn, the contents of the benefit plan must be summarized in a "summary plan description" which the plan must furnish to its participants in accordance with rules set forth in ERISA. 29 U.S.C. §§ 1022, 1024(b).

Given ERISA's roots in the traditional law of trusts, it is not surprising that plan documents play a central role in ERISA's structural design and administrative scheme. A significant and noteworthy feature of the statute is that Congress refrained from attempting to regulate either the substantive details of trust administration or the substantive content of welfare benefit plans. Having recognized that employee benefit funds differ from each other in so many respects, ERISA's drafters did not enumerate a comprehensive list of specific acts which the trustees were required to perform or of specific benefits the trustees were required to provide in order to fulfill their fiduciary obligation to conserve the trust assets committed to their care and control and to provide benefits to participants and beneficiaries.¹¹

Rather, ERISA imposes a few affirmative duties on trustees and contains a few specific prohibitions, leaving the details of trust administration to be articulated in written plan documents, which are tailored to the needs and purposes of the particular plan or trust, and

¹¹ Correspondingly, this Court and other courts have recognized that self-funded employee benefit plans are not required to provide state-mandated health benefits. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985); *Liberty Mutual Ins. Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989).

which function as the blueprint for its governance. What Congress did mandate, however, is that trustees have a fiduciary obligation to act in accordance with the plan's governing documents, *i.e.*, to apply and enforce them to the extent these documents are consistent with ERISA. 29 U.S.C. § 1104(a)(1)(D).

Given the structure, design, and trust law roots of ERISA, a paramount federal interest clearly exists in protecting the integrity of plan documents by permitting plan sponsors *uniformly* to apply and enforce any provision, term, or rule that is consistent with that statute. Indeed, since trustees have a *fiduciary duty* to administer employee benefit plans in accordance with the plan documents, maintaining the integrity of these instruments is a "core" ERISA concern. The Third Circuit failed to examine the subrogation provision of FMC's plan in this light and, in barring its enforcement, took no account of the structural design of ERISA and the administrative realities of employee benefit plans.

B. State law should not be permitted to interfere with core ERISA concerns by preventing plan sponsors from designing and implementing uniform cost-containment strategies in response to escalating health care costs.

Since ERISA was enacted to promote the financial stability of employee benefit plans and to assure that their participants receive the benefits upon which they rely, *Nachman v. PBGC*, 446 U.S. 359 (1980), the Third Circuit's ruling, which limits the scope of ERISA's preemption provision by expanding the reach of the "savings" clause, must be assessed against the background of America's health care crisis. Reports are legion that the costs of providing health care have escalated out of all proportion and are threatening to destroy private welfare plans. Consequently, there can be no state interest in permitting a plan participant to obtain a double recovery for medical expenses paid by the plan. In per-

mitting a state insurance law to preclude enforcement of a plan's subrogation provision, the Third Circuit issued a ruling that conflicts with federal law and policy by failing to take into account the environment in which the plan operates and to which it must respond.

In 1987, according to data of the United States Health Care Financing Administration and Department of Commerce, national health expenditures represented a record 11.1% of the Gross National Product. 10 Employee Benefit Notes No. 2 at 3 (Feb. 1989). This figure is expected to reach nearly 12% in 1990 compared with 9.1% in 1980. *Trends in Medical Care Costs: A Look at the 1990s*, 71 Statistical Bull. No. 1 at 28 (Jan.-Mar., 1990).

One well-publicized study states that the cost of employer-provided medical plans skyrocketed 20.4% in 1989 and is expected to rise at a rapid pace.¹² Health spending could reach \$661 billion in 1990, reports the Commerce Department in its recently released 1990 U.S.

¹² 17 Pens. Rep. (BNA) 260 (Feb. 5, 1990), reporting on a survey conducted by A. Forster Higgins & Co., a benefit consultant. Surveys of health care costs abound. Although all agree that the cost of providing medical benefits has escalated in recent years, the results of the surveys vary depending upon the companies and plans surveyed. One study by a Connecticut-based firm, Corporate Health Strategies, which surveyed 21 employers having more than 200,000 employees below the age of 65, reported that the cost of providing health benefits soared 71% between 1983 and 1988. 23 Bus. Ins. No. 40 at 6 (Oct. 2, 1989). On the average, the increases appear to range from 10% to 25%. Increased costs are attributable, in varying degree, to the following factors: medical inflation (increase in hospital charges and physicians' fees); demand for and use of the latest and most sophisticated technology; increased claims for catastrophic problems such as AIDS, transplants, and neonatal care; shifting of costs by hospitals and doctors from the public to the private sector; increased utilization of inpatient and outpatient services; malpractice premiums and the use of "defensive" medicine. *Data Watch: What's Driving Health Care Costs?*, 7 Business and Health No. 1 at 6 (Jan. 1989).

Industrial Outlook. 20 Modern Healthcare No. 1 at 34 (Jan. 8, 1990). Correspondingly, the cost of health insurance is rising more than three times as fast as wages. 7 Benefits Today (BNA) No. 1 at 16 (Jan. 12, 1990). In 1988, according to data recently released by the Bureau of Labor Statistics, before-tax household income rose 4.4% while health insurance costs to consumers jumped 21%. Daily Lab. Rep. (BNA) No. 39 at B-1 (Feb. 27, 1990). This upward spiral is not abating.

According to a Department of Labor report, purporting to provide representative data for 31.1 million full-time employees in private nonagricultural industries, a growing trend is emerging toward self-funded plans. *Employee Benefits in Medium and Large Firms, 1988*, DOL Bur. of Lab. Stat. Bull. No. 2336 at 36 (Aug. 1989). However, self-funded plans have experienced increased health care costs ranging from 10% to 20% and project 1990 cost increases of up to 25%. 23 Bus. Ins. No. 52 at 18 (Dec. 25, 1989).

Collectively-bargained multiemployer plans are almost universally self-funded. In addition to the problems posed by inflationary health care costs, these plans are also affected by fluctuations in the economic climate. Thus, in periods of economic growth, contributions tend to increase because there are more "hours worked." At such times, workers also tend to postpone medical treatment. Conversely, in periods of economic downturn, contributions decrease while claims on the funds grow. Hence, many welfare funds are unable to keep pace with the rising cost of the medical benefits promised in their plans, particularly since such funds also tend to invest conservatively, with an eye toward safety and liquidity. Burroughs & Zurawell, *Health, Welfare Funds Suffer Sharply from Higher Health Costs*, 25 Pen. World No. 11 at 24 (Nov. 1989).¹³

¹³ One NCCMP affiliate, an upstate New York based Carpenters Welfare Fund, reported that it is currently experiencing a contribu-

ERISA imposes on the trustees of multiemployer plans a fiduciary obligation to act "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." 29 U.S.C. § 1104(a)(1)(B).

Not surprisingly, the trustees of multiemployer welfare plans have been forced to consider and adopt a variety of cost-containment strategies to assure the continued viability of the plans. Among these strategies are: increased deductibles, ceilings on annual and or lifetime benefits; caps on claims for specific types of covered benefits (typically, treatment for alcohol and substance abuse, AIDS, and mental disorders); complete elimination of coverage for certain problems and procedures; reduced or eliminated coverage for dependents and retirees; and higher co-payment requirements. Alternatively, or additionally, employers have been required to contribute at higher rates in order for existing plan benefits to be maintained and for benefits to be improved.

However, unions and employers have both resisted one or more of these strategies, and bargaining over health coverage has led increasingly to labor disputes. For example, a 17-week strike at NYNEX Corporation, having 40,000 employees at the New York Telephone Company represented by the Communications Workers of America, centered on health insurance coverage. A similar strike by the Company's 20,000 employees repre-

tion decline due to a recessionary climate in the home building industry. At the same time, the Fund, which provides benefits to about 600 active employees and 100 retirees and their dependents, has received increased claims for substance abuse and alcohol-related problems. In response, the plan has recently imposed a co-payment requirement (80/20) and placed a cap on claims for clinical and psychological treatment.

sented by the International Brotherhood of Electrical Workers at the New England Telephone Company was over the same issue. Both unions were ultimately successful in preserving benefits with no employee co-payments. 16 *Pens. Rep.* (BNA) 2094 (Dec. 11, 1989). A 10-month strike by the United Mine Workers against the Pittston Coal Group also centered on health coverage as did strikes in other industries from retail food to auto parts. 16 *Pens. Rep.* (BNA) 2025 (Nov. 27, 1989).

A three-year study prepared by the Service Employees International Union, *Labor and Management: On a Collision Course over Health Care*, while recommending a "systemic change" in the way health care is provided, states that the number of strikes over who will pay the rising costs of health care has increased by more than 300% since 1986, and that such work stoppages in 1989 alone cost the United States economy more than \$1.1 billion dollars in lost wages and productivity. 17 *Pens. Rep.* (BNA) 375 (Feb. 26, 1990).

Two cost-containment strategies that do not increase the financial burden either on employers or on employees and do not require the reduction or elimination of benefits are coordination of benefits and subrogation. These strategies are therefore favored by the trustees of multi-employer plans.¹⁴

¹⁴ The NCCMP will limit its discussion to subrogation since the Third Circuit's decision involved only the antistubrogation provision of the Pennsylvania automobile insurance statute. However, the court of appeals, in enunciating its new test to determine whether a state law should survive ERISA preemption, relied heavily on a 1987 Sixth Circuit decision which, for similar reasons, "saved" the coordination of benefits provision of Michigan's no-fault statute from preemption and therefore barred enforcement of a conflicting coordination of benefits provision in a self-insured plan subject to ERISA. *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987). Coordination of benefits are rules that prevent duplicate recovery where a participant is covered by more than one plan or policy. Cost containment is achieved by a plan by

Like coordination of benefits, subrogation prevents a participant from obtaining a double recovery. Cost containment is achieved by requiring the participant to reimburse the plan for expenses paid in connection with an injury arising from an accident if and to the extent the participant recovers these expenses from a third party. Most subrogation claims arise in connection with automobile accidents. However, plans can seek reimbursement from the participant's recovery in other liability insurance contexts as well, for example, home owners, malpractice, dram shop, or worker's compensation.¹⁵

Multiemployer plan subrogation programs typically operate as follows. If the claim form submitted by the participant indicates facts suggesting that a third party may be liable for the expenses, the participant (and, if

deeming itself "secondary" and the "other insurance" primary. Under Michigan's no-fault statute, however, health insurance is considered primary and no-fault automobile insurance secondary if the no-fault insurer offers and the insured elects to coordinate benefits with his or her health insurance.

In *Northern Group Services*, the Sixth Circuit ruled that the no-fault insurance would be considered secondary regardless of the language of the health insurance plan, stating that there was no ERISA interest in uniformity that outweighed the McCarran-Ferguson Act interest in state regulation of insurance. As applied to multiemployer plans, the Sixth Circuit's decision is no less inimical to ERISA's core concerns than the Third Circuit's ruling at bar, since the effect of the two decisions is to preclude multi-employer plans from fully utilizing the *only* cost-containment strategies that do not limit benefits or impose additional costs on participants and beneficiaries or employers.

¹⁵ Most plans expressly exclude coverage for work-related injuries. However, whether an injury is work-related is often in dispute. Typically, the plan will pay the participant's medical expenses on condition that the plan will be reimbursed if the participant recovers from the worker's compensation carrier. The advantage to the participant in this and similar situations is that his or her medical expenses will be paid when needed and disputes will be resolved at a later time.

appropriate, the dependent) is required to sign an agreement promising to reimburse the plan in the event of a recovery as a condition to receiving the benefits claimed. The participant is not required to file suit against a third party, but may not do anything to prejudice the plan's recovery. At a minimum, the participant is therefore required to notify the plan whether or not he or she intends to file a claim with an insurance company or to file suit against a tortfeasor and, if so, to provide the plan with relevant information. The plan may take such action itself, although it is not required to do so. Usually, the plan, through counsel, simply files subrogation liens with all relevant insurance companies and attorneys, thereby notifying them of its subrogation interest. Though a plan may sometimes intervene in a participant's action to protect its lien, such action is frequently unnecessary. The majority of personal injury claims are settled out of court and insurance companies and attorneys tend to honor subrogation liens filed by multiemployer plans.

Although statistics are not yet available to "prove" the effectiveness of subrogation programs,¹⁶ it is clear that such programs constitute a cost-effective, efficient way for plans to respond to escalating health care costs.¹⁷

¹⁶ One 1984 study suggests that a vigorous subrogation program can result in the recoupment of 1% to 2% of all medical claims paid and can be much more. Wille, *Subrogation Third Party Reimbursement: An Overlooked Way to Reduce Health Benefit Costs*, 1 Health Cost Management No. 9 at 3 (June 1984).

¹⁷ The NCCMP cannot offer the Court statistics on the success rate of its affiliates' subrogation programs, in part, because this method of cost-containment is relatively recent. However, by way of example, the Southern Electrical Health Fund has recently initiated a vigorous subrogation program. In the past six months, a total of 63 files were opened, involving claims totalling \$513,596.01. Twenty-one cases have since been closed, of which seven were deemed uncollectible for procedural reasons. The fourteen remaining cases yielded payments of \$63,064.24. The plan expects to collect a further \$149,570.57 on twelve additional claims. Ten pending claims, in-

However, if the Third Circuit's ruling is not reversed, these programs (and other cost-containment measures such as coordination of benefits) will be seriously hampered because a key feature of multiemployer plans is that their participants reside or work in different states and may also move from state to state in covered employment without losing their eligibility for benefits. Given the variety of state laws regulating automobile and other types of liability insurance, including worker's compensation, multiemployer plans will be faced not only with administrative uncertainty and increased administrative costs as a result of differing state schemes but also with a potentially significant loss of revenue since some of these state laws bar subrogation (and or coordination of benefits) and a participant could select one of these fora specifically to prevent the plan's recovery. *Howard v. Alfrey*, 697 F.2d 1006 (11th Cir. 1983). Such results are not tangential to "core" ERISA concerns, as the Third Circuit erroneously believed; they are contrary to and undermine the basic purposes and principles of the statute.

In sum, there can be no state interest in permitting plan participants to obtain a double recovery for medical expenses while the nation's health care system is in crisis and escalating costs are threatening to destroy private welfare plans. Given the Third Circuit's illustrative failure to recognize a "core" ERISA concern, the NCCMP urges this Court to reject the test enunciated by the court of appeals, to reaffirm the bright-line distinction it articulated in *Metropolitan Life*, and to reverse the holding below.

volution \$115,273.33, do not appear favorable. However, if SEHIF succeeds in collecting \$212,634.81, as expected, the plan will have recovered 41.40% of its current subrogation claims solely by filing liens and without litigation. In an average month, the plan extends coverage to about 2,557 eligible participants. In 1989, it paid \$6,821,861.45 in claims (an increase of 16.5% over 1988). In 1989, employer contributions totalled \$7,015,539.94 (a 2.9% increase over 1988). Thus, the plan's expected recovery on its 63 initial subrogation claims is roughly 3.10% of total claims paid in 1989.

II. SECTION 514(b)(2)(B) OF ERISA WAS INTENDED TO PREEMPT ALL STATE INSURANCE REGULATION AFFECTING SELF-FUNDED EMPLOYEE BENEFIT PLANS AND THE THIRD CIRCUIT'S RULING IS INCONSISTENT WITH DECISIONS OF THIS COURT AND THE WEIGHT OF APPELLATE AUTHORITY.

The NCCMP supports the arguments set forth in Petitioner's brief and will limit its discussion here to those aspects of the Third Circuit's ruling that are particularly adverse to the efficient, cost-effective administration of multiemployer plans and their financial soundness.

A. The Third Circuit's ruling abandons the bright-line test for preemption that is necessary for the uniform administration of multiemployer plans.

In *Metropolitan Life Ins. Co. v. Massachusetts*, *supra*, this Court, after examining the language of ERISA, its legislative history, and its own previous decisions, concluded that Congress was fully aware that two distinct types of benefit plans were covered by ERISA (insured and self-funded), and that Congress intended to exempt self-funded plans from the direct effects of all state insurance regulation.

The Courts of Appeals for the Fourth, Fifth, Seventh, Eighth and Ninth Circuits have followed the bright-line distinction set forth in *Metropolitan Life* in a variety of factual contexts,¹⁸ implicitly or explicitly recognizing the adverse consequences of an alternative approach for the administration and financial soundness of self-funded plans.

¹⁸ *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986); *Children's Hosp. v. Whitcomb*, 778 F.2d 239 (5th Cir. 1985); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416 (7th Cir. 1988), *cert. denied*, 109 S. Ct. 145 (1988); *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986).

In contrast, the Third and Sixth Circuits,¹⁹ reasoning that this Court's distinction between insured and self-funded plans is dictum, departed from *Metropolitan Life* and established new tests by which to determine whether a state insurance law or regulation is "saved" from the reach of the "deemer" clause and therefore from federal preemption.

In the Third Circuit's view, the proper inquiry is not whether a plan is insured or self-funded, but whether the "state insurance regulation intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision." 885 F.2d at 90. However, while eschewing the *Metropolitan Life* distinction, as well as its "categorical" application by the Ninth Circuit in *Pacyga*, *supra*, the court of appeals nevertheless states (as does the Sixth Circuit) that the distinction does not "disappear." Rather, insured plans *per se* survive the "deemer" clause, which would therefore permit application of state insurance law, while self-funded plans would be considered on a "case by case" basis to determine whether the state law "conflicts with a substitute mandate in ERISA." *Id.*

Opining that the "deemer" clause was primarily intended to protect ERISA plans from "intentional" or "pre-textual" attempts by states to regulate them in the guise of insurance, the Sixth Circuit ruled in *Northern Group Services*, *supra*, that "for the deemer clause to override the savings clause in a given case, there must be some ERISA interest in uniformity to outweigh the McCarran-Ferguson interest in state regulation of insurance." 833 F.2d at 95.

The tests suggested by both courts are confusing and likely to lead to administrative uncertainty for multiem-

¹⁹ *FMC Corporation v. Holliday*, 885 F.2d 79 (3d Cir. 1989); *Northern Group Services, Inc. v. Auto Owners Ins. Co.*, 833 F.2d 85 (6th Cir. 1987).

employer plans as well as to an increased potential for litigation and conflicting results.

If state insurance regulation is not *per se* preempted as applied to self-funded multiemployer plans, the first difficulty facing a plan administrator is the question of which state law will govern in the event of a perceived or claimed conflict with the plan document. As noted earlier, multiemployer plans administered in one state tend to cover participants who live and/or work in different states or who move from one state to another in covered employment. Typically, the trust agreement governing the plan will provide that the law of the state in which the trust is administered will govern the operation of the trust except as preempted by ERISA. If ERISA does not, as a matter of federal law, mandate enforcement of all plan documents and a participant is involved in an accident in another state, the plan administrator will have to determine, first, which state's law is likely to apply so as to determine how benefits should be coordinated or whether a subrogation claim should be made. Since complex conflict of laws issues may arise, subrogation and coordination of benefits will no longer be routine matters, and it may become necessary for the plan to involve counsel increasingly in the processing of claims. Thus, subrogation and coordination of benefits will lose some of their effectiveness as cost-containment mechanisms. Moreover, either federal courts will have to develop a body of federal conflicts law to resolve disputes between state laws and plan documents or the enforcement of plan documents will be subject not only to state insurance laws but also to state conflicts rules in derogation of a paramount federal interest in the uniform federal regulation of employee benefit plans.

Even if there is no difficulty in determining which state's law should apply, federal courts, when asked to resolve a conflict between enforcement of a plan document and state law, will be required, in each "given case," to

undertake an exhaustive review of the state law in question (including its legislative history and cases construing it) in order to determine such questions as: whether the state scheme seeks to regulate insurance or to regulate a plan in the guise of insurance; whether its effect on a plan is intentional or unintentional; if unintentional, whether its effect conflicts with a "substitute ERISA mandate;" and, if so, whether the substitute mandate is a "core type of ERISA matter" or one requiring "uniformity." As the Third and Sixth Circuits' opinions indicate, different and conflicting answers to such questions will be inevitable and may result in substantive holdings that are inimical to central tenets of ERISA. This has already occurred in the ruling below as well as in *Northern Group Services, supra*.

In *Holliday*, the Third Circuit barred enforcement of a plan's subrogation provision and permitted a participant to enjoy a double recovery to the detriment of the plan because it failed to recognize as a "core type of ERISA matter" that plan sponsors have a fiduciary obligation to design and implement all measures that are reasonable and necessary in the circumstances to conserve plan assets so that the plan can pay the benefits promised to its participants and beneficiaries. Significantly, the court of appeals upheld the state statute's antisubrogation provision merely because it was there. Not the slightest attempt was made to show how the antisubrogation provision of the Pennsylvania law was even arguably related to a state interest worthy of protection under the McCarran-Ferguson Act, the federal statute that underlies ERISA's "savings" clause and returns to the states the business of regulating insurance companies and insurance contracts. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). Consequently, in its first departure from *Metropolitan Life*, and its first attempt to apply its own test to a self-funded plan on a "case by case" basis, the court made a ruling that, in barring subrogation, will certainly affect the FMC

plan adversely and threatens the financial soundness of every self-funded plan in the nation as well.

In *Northern Group Services*, the Sixth Circuit achieved an equally ominous result by striking down a plan's coordination of benefits rule on the grounds that the plan's provision conflicted with Michigan's no-fault insurance law. In contrast to the Third Circuit, the Sixth Circuit devoted much of its opinion to justifying Michigan's interest in assuring that the coordination of benefits provisions of no-fault policies are uniformly interpreted to place primary liability on the insured's health policy or plan instead of on his or her automobile insurance carrier. Turning proper preemption analysis on its head, the court indicated that the state insurance law should not be preempted, even as applied to a self-funded plan, because preemption would frustrate the state's goals of cost containment, predictability, and the financial stability of no-fault insurers. 833 F.2d at 93. The court could find no countervailing federal interest in uniformity to outweigh the state's interest in preserving its own insurance scheme, although the goals set forth in support of "saving" the state law are *precisely* those which, as applied to a self-funded plan, would require federal preemption because they promote "core types of ERISA matters."

Significantly, another panel of the Sixth Circuit departed from *Northern Services* and declined to interpret Michigan's no-fault insurance statute to require a plan to provide coverage for injuries arising out of automobile accidents. The court ruled that even if the Michigan statute required this result, it would be preempted in the same way that mandated-benefits statutes are preempted as applied to self-funded plans. *Liberty Mutual Ins. Group v. Iron Workers Health Fund of Eastern Michigan*, 879 F.2d 1384 (6th Cir. 1989).

In contrast to these decisions, the majority of courts of appeals have followed the bright-line test set forth

in *Metropolitan Life*, and have exempted from the reach of the "savings" clause all self-funded employee benefit plans. In so doing, these courts have recognized that this Court has rejected as unworkable the conflict-oriented analysis of the "deemer" clause espoused by the Third and Sixth Circuits, and has already provided common-sense guidelines to assure that self-funded employee benefit plans will be uniformly protected against the incursion of state insurance regulations. A bright-line test is necessary for the efficient, cost-effective administration of self-funded employee benefit plans, especially multiemployer plans. The NCCMP therefore urges this Court to reject the analyses of the Third and Sixth Circuits and to reaffirm its interpretation of the "deemer" clause as set forth in *Metropolitan Life*.

B. This Court's distinction between insured and self-funded plans is consistent with the text and legislative history of ERISA and should be reaffirmed in the case at bar.

Departing from *Metropolitan Life*, the Third Circuit objected that this Court read into the statute a distinction that was not there, thus permitting the "deemer" clause to "swallow" the "savings" clause. This contention is clearly error, particularly as applied to collectively-bargained self-funded multiemployer benefit plans that are maintained and established as trusts within the meaning of Section 302(c)(5) of the Labor-Management Relations Act, 1947, as amended, 29 U.S.C. § 186(c)(5), and Sections 402 and 403 of ERISA, 29 U.S.C. §§ 1102 and 1103.

Section 3(1) of ERISA defines an "employee welfare benefit plan" as any "plan, fund, or program" that provides health or medical benefits "either through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). Section 4(a) provides that Title I of the statute, except as expressly excluded, covers any "employee benefit plan" that is established or maintained by an employer, a union,

or both. 29 U.S.C. § 1003(a). Finally, Section 514(b)(2)(B) of ERISA provides that “neither any employee benefit plan described in section 1003(a) . . . nor any trust established under such a plan” shall be “deemed” to be an insurance company, an insurer, or to be engaged in the business of insurance for the purpose of state laws regulating insurance and saved from federal preemption by Section 514(b)(2)(A). 29 U.S.C. § 1144.

Applying the plain meaning rule for construing statutes as well as common sense, this Court recognized that ERISA, on its face, clearly covers two distinct types of benefit plans, those which provide benefits through the purchase of insurance from commercial insurance companies that are themselves subject to state regulatory schemes, and those which provide benefits from corporate assets or employer contributions and which Congress intended to exempt from state regulation. The text of ERISA fully supports the Court’s distinction in *Metropolitan Life*, particularly as applied to collectively-bargained multiemployer trust funds whose corpus consists of employer contributions. Contrary to the Third Circuit’s view, the distinction between insured and self-funded plans does not “swallow” the “savings” clause but permits states now as before to regulate commercial insurance companies and their contracts (though not the plans themselves) while leaving the plan sponsors of self-funded plans free to make benefit decisions that are sensitively tailored to the needs of their specific plans in accordance with ERISA’s fiduciary duty rules.

When asked to review whether a particular state law is preempted by ERISA, this Court has repeatedly stated that “as in any pre-emption analysis, ‘the purpose of Congress is the ultimate touchstone.’” *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 8 (1989). ERISA’s sponsors have stated this purpose with great clarity. Thus, Representative Dent asserted that “with the preemption of the field [of employee benefits], we round out the protection

afforded participants by eliminating the threat of conflicting and inconsistent local regulations.” 120 Cong. Rec. 29197 (1974). Senator Williams made similar statements. *Id.*, at 29933. In this Court’s view, “these statements reflect recognition of the administrative realities of employee benefit plans.” *Id.* at 9.

Speaking of self-funded single-employer plans, the Court observed that “[a]n employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others. . . .” *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 9.

Given these difficulties, this Court indicated that it was prepared to enforce ERISA’s preemption provision whenever necessary to prevent the subordination of a plan’s administrative scheme to conflicting state insurance regulation. The difficulties besetting self-funded single-employer plans are magnified in the case of self-funded multiemployer plans. As the Court recognized in *Fort Halifax*, however, federal preemption assures that the administrative practices of employee benefit plans will be governed by a single set of regulations, as Congress intended, rather than by a patchwork scheme of conflicting state law. *Id.*, at 11. The Third Circuit’s rul-

ing is inconsistent with these principles and should be reversed.

CONCLUSION

ERISA provides and Congress intended that self-funded welfare benefit plans be exempt from the reach of state insurance regulation, in recognition of the administrative realities of such plans and the need for uniformity. The Third Circuit, misperceiving the text and the legislative history of the statute, has created a new and disruptive test to determine whether a state insurance law should survive federal preemption. In so doing, the court has placed serious limits on the ability of multiemployer welfare plan trustees to rely on a plan's governing documents to implement a uniform system of trust administration and to respond effectively to the escalating costs of health care. The court of appeals' failure to identify "core" ERISA concerns illustrates that its conflict-oriented "case by case" interpretation of the "deemer" clause is unworkable and inconsistent with the central purposes and policies of ERISA. For all of the reasons stated above, the NCCMP respectfully urges this Court to reverse the decision of the Third Circuit and to reaffirm the bright-line test for preemption set forth in *Metropolitan Life*.

Respectfully submitted.

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